Public Hearing on the Maternal Fatalities and Morbidities Advisory Committee

Committee Selection, Process Review, and Draft Recommendations

October 30,2019

ARIZONA DEPARTMENT OF HEALTH SERVICES
Health and Wellness for all Arizonans

Martín F. Celaya, MPH
Office Chief, Assessment and Evaluation
Bureau of Women's and Children's Health

Presentation Objectives

- Provide an overview of the Arizona Maternal Mortality Review Program (MMRP)
- Present on the current methods of identifying maternal deaths and severe maternal morbidity cases
- Discuss the selection process of the Advisory Committee on Maternal Fatalities and Morbidities (henceforth referred to as the Committee)
- Discuss the methods and meetings of the Committee (current events)
- Review the draft recommendations set by the Committee
- Provide an update on future Committee milestones
- Engage the public and collect the public's input

Arizona Maternal Mortality Review Program (MMR)

Established by the Arizona Senate Bill 1121 on April 2011. Review of cases began July 2011

Authorized the Child Fatality Review Program to create a subcommittee to review all identified pregnancy associated deaths

Multidisciplinary team reviews cases to identify preventative factors and produce recommendations for systems level changes

The first inaugural report was published in February 2013 which encompassed data for part of calendar year 2011 and all of 2012

Report released on June 1, 2017

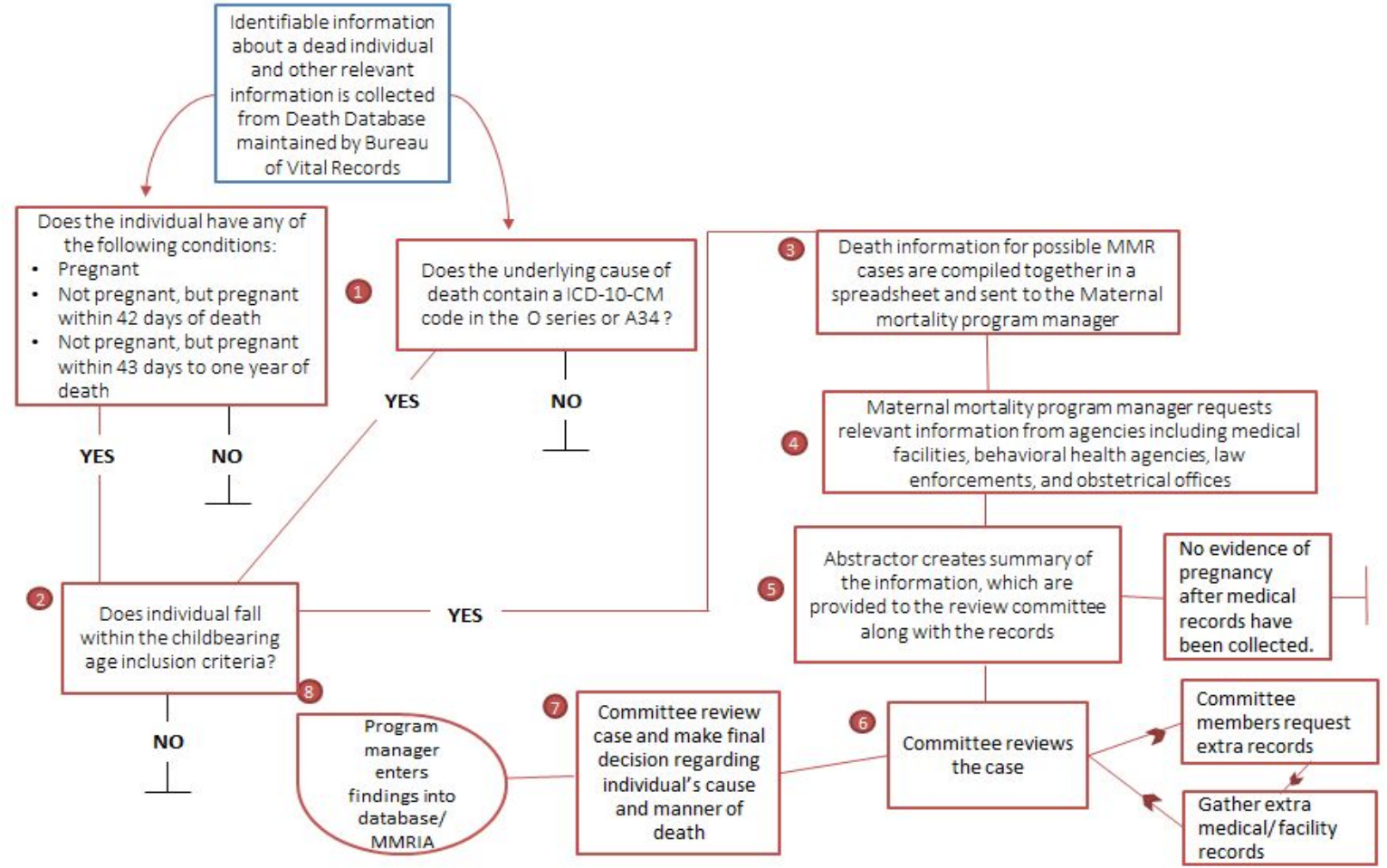
*"12. Evaluate the incidence and causes of **maternal fatalities** associated with pregnancy in this state. For the purposes of this paragraph, "maternal fatalities associated with pregnancy" means the death of a woman while she is pregnant or within one year after the end of her pregnancy."*

ARS 36-3501

Current Methods of Identifying Maternal Deaths and Severe Morbidities

Katherine Lewandowski, MPH
Maternal and Child Health Epidemiologist
Bureau of Women's and Children's Health

Maternal Mortality Review
Case Identification and Data Flow



Severe Maternal Morbidities (SMM)

Uses the Arizona Hospital Discharge Database

Identifies SMM cases among Arizona resident births who have:

- A delivery hospitalization in the Hospital Discharge Database
- At least 1 of 21 diagnosis or procedure indicators:
    - organ-failure (acute renal failure, cardiac arrest, shock, etc.)
    - clinical signs and symptoms (eclampsia, sepsis, pulmonary embolism, etc.)
    - management of conditions (blood transfusion, hysterectomy, ventilation, etc.)
- At least 1 qualifying condition:
    - Length of hospital stay at least 4 days for vaginal or primary cesarean delivery or 5 days for repeat cesarean delivery
    - The mother was transferred before or after delivery to a different facility
    - The mother died during delivery hospitalization
    - At least one of the 5 procedure indicators was present (blood transfusion, hysterectomy, etc.)

Maternal Fatalities and Morbidities Advisory Committee

Martín F. Celaya, MPH
Office Chief, Assessment and Evaluation
Bureau of Women's and Children's Health

SB1040: Advisory Committee

- Signed by Governor Doug Ducey on April 29, 2019
- Establishes an Advisory Committee on Maternal Fatalities and Morbidity

Objective

The committee is established to recommend improvements to information collection concerning the incidence and causes of maternal fatalities and severe maternal morbidity.

Legislative Specifications

- DHS in conjunction with the advisory committee shall hold a public hearing to receive public input regarded the recommended improvements to information collection.
- On or before 12/31/19 the advisory committee shall submit to the chairpersons of the HHS committees a report with recommendations concerning improving information collection
- On or before 12/31/20 DHS shall submit a report to the governor and others on the incidence and causes of maternal fatalities and morbidities that includes all readily available data through the end of 2019.

SB1040: Membership

DHS Director or designee shall serve as the chairperson of the committee.

One of the members of the advisory committee shall come from a county with a population of less than 500,000.

The advisory committee consists of the following members:

- A Health Plan representative from each geographic service area (3) designated by the Arizona Health Care Containment System
- Arizona Health Care Containment System (1)
- Indian Health Services (1)
- Obstetrician (1) licensed pursuant to title 32, chapter 13 or 17, Arizona Revised Statutes
- Maternal Fetal Medicine Specialists (2) licensed pursuant to title 32, chapter 13 or 17, Arizona Revised Statutes
- Certified Nurse Midwife (1), licensed pursuant to title 32, chapter 15, Arizona Revised Statutes
- Nonprofit organizations (2) that provide education, services or research related to maternal fatalities and morbidity
- State Health Information Organization (1)
- Public Health Organization (1)
- Hospital Organizations (2)
- An Advisory Committee Member from a county with a population less than five hundred thousand (1)

Committee Selection Process

- The Department enacted an open application process via the landing page: www.azdhs.gov/maternalhealth
- Stakeholders and the public were invited to apply to be selected for membership in the committee
- Application period was open for 6 business days

Applicants submitted their updated resume/CV and their responses to the following questions:

1. Please describe your interest in becoming a member of this committee
2. Please list your education, current employment, and licenses
3. Please list associations and memberships with professional organizations
4. Select a Committee Position Representation

Committee Selection Process

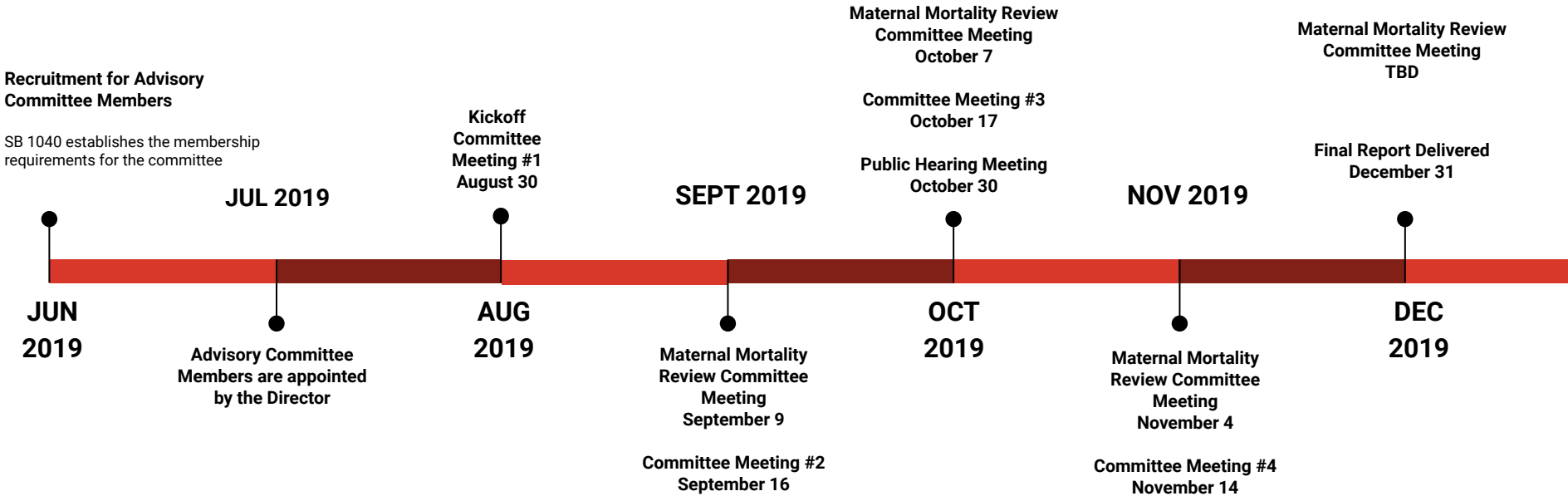
- 30 applications were submitted to the Department
- Applications were reviewed by the Bureau of Women's and Children's Health Chief as the Director's designee and the Assistant Director for the Division of Public Health - Prevention Services to ensure that all committee representation roles were assigned per SB1040
- The 16 selected members were e-mailed a letter of appointment signed by the Director on July 18, 2019
  - The notification letters included the committee member's assigned role in the Committee; the purpose of the Committee; and a copy of SB1040
  - Pursuant to A.R.S. 38-592 and 38-231 all committee members were required to participate in Public Service Orientation training (also known as Standards of Conduct) and sign a loyalty oath
- All selected members accepted the appointment by the Director
- Applicants who were not selected (14) were notified and invited to participate as members of the public in upcoming Committee meetings

SB1040: Membership

Patricia Tarango MS	Bureau Chief, Bureau of Women's and Children's Health, Arizona Department of Health Services
Satya Sarma MD	Senior Medical Director, Care 1st Health Plan
Maritza Jimenez LPN	Senior Quality Improvement Project Manager (Medicaid Programs), Care 1st Health Plan
Carl Bronitsky MD	Obstetrician, San Carlos Apache Healthcare
Charlton Wilson MD	Chief Medical Officer, Mercy Care
Eric Tack MD JD MPH	MCH/EPSDT Program Director, Arizona Health Care Cost Containment System (AHCCCS)
Amy Lebbon RN CNM IBCLC	Acting Chief of Nurse Midwifery Services, Phoenix Indian Medical Center
Cynthia Booth MD	Obstetrician, Banner Payson Medical Center
Mike Foley MD	Maternal Fetal Medicine Specialist, Chair - Department of OBGYN COMP, University of Arizona, College of Medicine
Guadalupe Herrera-Garcia MD	Maternal Fetal Medicine Specialist, Genesis OBGYN
Diana Jolles PhD CNM FACNM	Staff Midwife, El Rio Community Health Center
Breann Westmore	MCH & Government Affairs Director, March of Dimes Arizona
Mary Ellen Cunningham RN	President/RN, Arizona Public Health Association
Mike Mote	Chief Strategy Officer, Health Current
Michael Madsen MD	Medical Examiner, Coconino County Public Health Services District
Sandy Severson RN	Vice President Care Improvement, Arizona Hospital & Healthcare Association
Jennifer Carusetta	Executive Director, Health System Alliance of Arizona
Robert "BJ" Johnson MD	Maternal Fetal Medicine Specialist, Arizona Perinatal Trust

Timeline and Methodology to Produce Recommendations

SB1040: Advisory Committee Timeline



Selected Methodologies

Key Informant Interviews

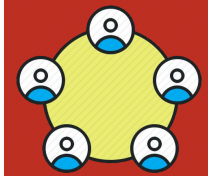
Members interview individual key members of the MMRC and program staff on the MMR process, challenges, and areas for improvement.

Observational Assessments

Members attend an upcoming MMRC meeting as observers and notate information on the performance of the MMR process. They are not active participants of the review process.

Panel Discussion

Key program staff and MMRC members form the panel. The advisory committee members pose questions to the panel regarding the process and other relevant items.



Roundtable Discussion

The advisory committee holds a facilitated discussion about identified challenges in the process and generate recommendations for improvement.

Support for Advisory Committee Activities

ADHS Staff

- Administrative support
- Data collection and entry assistance
- Note taking and documentation
- Logistics and scheduling
- Technical assistance on methodology implementation
- Draft recommendations report

Advisory Committee

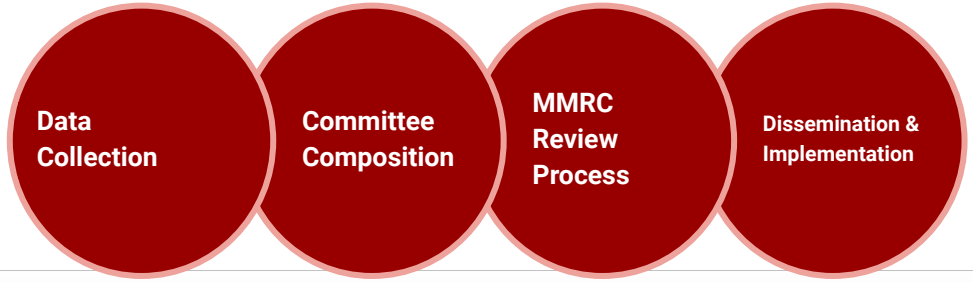
- Implement chosen methodology
- Organize and facilitate public hearing
- Develop recommendations based on review findings
- Review and provide feedback on report drafts
- Transmit report to chairpersons of HHS committees

Meeting 1 Objectives and Activities (August 30)

- Provided an overview of Senate Bill 1040, the roles and responsibilities of the Committee
- The Department gave a presentation to the Committee regarding the current case identification, data collection, and review process of the Maternal Mortality Review Program.
- The Department gave a presentation on the current data collection process for Severe Maternal Morbidities.
- The Department presented sampled methodologies for Committee consideration and use: Key Informant Interviews, Observational Assessments, and Panel Discussions.
  - The committee selected a mixed method approach involving all three of the sampled methodologies as well as a roundtable discussion.
- The Department was asked to produce one-page summaries of challenges and proposed solutions on **data challenges and gaps**, **committee composition**, the **MMRC committee process**, and **dissemination of findings and implementation** for review at the upcoming Committee meeting.
- A timeline for anticipated Committee activities was discussed and approved.

Meeting 2 Objectives and Activities (September 16)

- The Department gave an overview of the identified challenges and possible solutions for the Maternal Mortality Review process.
- The committee engaged in a panel discussion with Department Staff to answer questions related to the identification of cases, records requests from hospitals and other facilities, and the MMRC overall.
- The committee engaged in a roundtable discussion to identify and select recommendations.
- A timeline for anticipated Committee activities was discussed and approved.



Meeting 3 Objectives and Activities (October 17)

- The Department received feedback from the Committee on a draft of the report sent prior to the meeting.
  - Initial feedback was incorporated and an updated version of the draft report was distributed at the meeting.
- The Committee engaged in discussion for additional review and edits to the draft report.
  - This included review of the proposed recommendations, with Committee additions and edits made as necessary.
  - Committee comments and all additional feedback was documented by the Department for incorporation into an updated draft of the report.
- The Committee agreed not to move forward with key informant interviews, feeling there was adequate interaction and information sharing between the Committee, the Maternal Mortality Review Committee, and Department staff to learn about the process and produce recommendations.
- A timeline for anticipated Committee activities was discussed and approved.

Draft Recommendations

of the Maternal Fatalities and Morbidities Advisory Committee

Recommendations: Data Collection Process

Maternal Mortality

Improve the sensitivity and timeliness of maternal death identification.

- Link identified maternal death cases with birth, fetal death, and HDD to gain additional information
- Determine a mechanism for utilizing the raw year-to-date death file to identify maternal deaths closer to the date of maternal death
- Explore a process for healthcare facilities to report confirmed maternal deaths to the Department within 30 days
    - Collaborate with the Arizona Perinatal Trust (APT) through a Memorandum of Understanding (MOU)/ Data Sharing Agreement (DSA) on possible monthly reporting of maternal deaths in APT certified facilities
    - Consider utilizing and building onto existing reporting requirements of birthing facilities, either through the establishment of MOUs with individual facilities or the development of an accountable mandated process for facilities to report confirmed maternal deaths

Recommendations: Data Collection Process

Strengthen and establish partnerships to facilitate a more efficient and comprehensive records acquisition.

- Build relationships across the state to decrease cycle time from record release
  - Identify sites that result in records request delays and provide technical assistance, especially for Health Information Management and Medical Records staff responding to requests
  - Develop a communication campaign for hospitals and other agencies to better understand the purpose of the MMRC and their role in contributing information to investigating maternal deaths
  - Execute MOUs/DSAs with agencies and entities whose information can support the review process including but not limited to AHCCCS, Tribal Governments, DPS, DCS, as such
  - Provide technical assistance to third party or centrally hosted record companies, including identifying a contact person at these entities to assist in timely responses to records requests
  - Emphasize that records for the MMRP are non-discoverable and are de-identified for MMRC use
- Identify additional datasets that can be queried for additional information
- Explore the possibility of data sharing via Health Information Exchange platforms, including the use of key indicators to identify cases of maternal death within the Health Information Exchange
- Develop screening questions for medical examiners to assist in identification of maternal deaths
- Invite staff members from Arizona Vital Records to the MMRC

Recommendations: Data Collection Process

Encourage development and implementation of protocols that streamline the record collection process, particularly for pregnancy-related deaths.

- Develop a protocol to enforce the time requirement for records request
- Increase real-time availability of records, especially of pregnancy-related deaths

Develop and implement ongoing quality assurance methods and evaluation of all MMRC processes.

- Establish a quality assurance plan with scheduled tasks to be followed on a routine basis by MMRP staff
- Create a checklist to be completed for each maternal death to coordinate the data process
- Reach out to CDC for technical assistance
    - CDC gave technical assistance to the Department on the MMR process in December 2018, and will provide ongoing technical assistance through 2020 as part of the CDC Preventing Maternal Deaths grant award
- Department was recently awarded the Maternal Mortality Review Grant that begins September 30, 2019, which includes technical assistance

Recommendations: Data Collection Process

Severe Maternal Morbidity

- Identify ways to partner with Indian Health Service (IHS), Tribal or 638 hospital facilities, and other non-HDD reporting facilities to better understand SMM in their sites
- Follow CDC and/or AIM guidance on the assessment of SMM cases
- Identify maternal mortality cases in the HDD dataset to support the review process
- Conduct routine surveillance of SMM twice a year, including the use of key indicators to identify cases in the Health Information Exchange
- Assess data quality by reporting facility to identify inconsistencies in reporting and code usage
- Produce annual data quality report on HDD data used to identify SMM cases
- Consider identification of SMM cases during pregnancy and postpartum, including re-admissions and admissions to the ICU or behavioral health care
- Coordinate and develop MOUs/DSAs with Managed Care Organizations or other content management systems to access core severe maternal morbidity metrics (transfusions and ICU admissions)

Recommendations:

Maternal Mortality Review Committee Composition & Governance

Construct governing guidelines to maximize committee structure and best practices.

- Develop governing bylaws for the MMRC to conduct business in a consistent manner:
  - Identify best practices regarding MMRC membership and participation
  - Develop formal committee tenure and term-limits with appropriate rotation of members
  - Draft clear definitions of committee roles
- Consider enacting a separate statute for Maternal Mortality Reviews
- Request technical assistance from the CDC on Committee Composition

Cultivate the diversity of the committee to introduce additional perspectives in case review and discussion.

- Increase participation of non-clinical MMRC members in the MMRC meeting to enhance the diversity of the MMRC
- Develop a recruitment strategy to address gaps and strengthen MMRC composition, including behavioral health, social service agencies, DCS, clinical specialists, community organizations, Indigenous communities, survivors, and representatives of various geographical, racial, and socioeconomic populations
- Design a formal process for inviting recruited MMRC members to apply

Recommendations:

Maternal Mortality Review Committee Composition & Governance

Provide member trainings to bolster confidence in their roles and improve the consistency of the review process.

- Develop a process manual of the MMRC
- Conduct standardized trainings for MMRC members, including new member orientation and annual refresher trainings for all MMRC members, to highlight the roles and responsibilities of committee members and an overview of the MMRC process
- Distribute additional training materials and resources to members to aid in MMRC review process

Develop and implement clear expectations of committee member attendance and participation.

- Develop and enforce guidelines and attendance expectations for participating organizations and members
- Document commitment by each MMRC member to the mission, vision, and expectations of the MMRC via a participation oath
- Identify challenges to participating in MMRC meetings
- Eliminate barriers to MMRC meeting attendance (webinar, reimbursement of travel, quarterly all day meetings)
- Develop an application process for MMRC membership

Recommendations: Maternal Mortality Review Process

Adopt strategies to improve the efficiency of case reviews, including prioritization of pregnancy-related deaths.

- Prioritize review of pregnancy-related deaths to be closer to when death occurred
- Pre-review cases by a committee subgroup
  - Consider developing a specialized subcommittees to review violence related deaths, accidental deaths, substance use related deaths, and pregnancy related deaths to later present findings to MMRC for final approval
- Preemptively organize the review of cases by pregnancy associated vs. pregnancy related and causes of death to increase efficiency in the reviews
- Develop quick reference guides and tools to facilitate the review process
- Complete abstracts well in advance of MMRC meetings and upload to MMRIA for MMRC members to access de-identified case narratives electronically in preparation of the MMRC meeting

Implement continuous quality improvement methods and process measures.

- Design and implement a quality improvement process to identify inefficiencies and produce timely solutions
- Incorporate components of the Arizona Management System into committee review for process standardization

Recommendations: Maternal Mortality Review Process

Complete the hiring process for a full time clinical nurse abstractor to respond to questions from the MMRC for each case review.

Establish feedback mechanisms to capture thoughts, concerns, and ideas from committee members.

- Implement an evaluation with MMRC members feedback to produce practical recommendations
- Internally log missed opportunities and inefficiencies identified in the review process for continuous quality improvement
- Conduct an environmental scan to assess the needs of the MMRC and the MMRC members (meeting times, location, barriers)

Follow CDC guidance and the Review to Action model to produce actionable recommendations.

- Request technical assistance from CDC to the MMRC on developing actionable recommendations
- Follow the Review to Action template to develop case-specific recommendations
- Review recommendations from others states' MMRCs for training

Propose a sustainability plan to support the MMRC that includes staffing (program manager, abstractor, epidemiologist), training, and other items necessary for the MMRC to continue functioning long-term.

Recommendations: Development of a Dissemination and Implementation Plan for MMRC Findings and Recommendations

Expand infrastructure and establish protocols for timely data analysis and generation of MMRC reports.

- Identify an epidemiologist or data analyst dedicated for data quality review, analysis, and report writing
- Develop a data subcommittee to oversee routine reporting of data from the MMRC
- Develop a standard reporting schedule of data and recommendations from the MMRC
- Develop and publish data dashboards with state-level aggregate process metrics on MMRC activities and recommendations for prevention of maternal deaths, according to the reporting schedule
- Update the maternal mortality landing webpage to report on current MMRC activities
- Develop and publish data dashboards with preliminary data on year to date reviewed cases
- Receive technical assistance from the CDC on the use of MMRIA to query timely reports
- Update the Department's Maternal Mortality and Severe Maternal Morbidity landing pages with up to date information
- Produce an updated report that includes data from deaths that have occurred since 2016
- Include stratification of data by race and ethnicity, as well as by mode of delivery in the upcoming report

Recommendations: Development of a Dissemination and Implementation Plan for MMRC Findings and Recommendations

Develop a plan and disseminate MMRC data and findings to stakeholders and partners.

- Develop a dissemination plan with MMRC input
- Develop and implement a robust public awareness strategy on maternal mortality and morbidity, the MMRC, it's activities, findings, and actionable recommendations
- Provide information and materials to MMRC internal and external stakeholders to share with the populations they serve, including a resource with clinical solutions and other recommendations
- Partner with home visitation and other service providers to provide information about maternal mortality and MMRC recommendations
- Present findings at stakeholder meetings
- Develop and launch a CEUs course for clinical and non-clinical providers on recommendations from the MMRC
- Conduct a statewide summit on severe maternal morbidity and mortality
- Develop a campaign for the general public about maternal death and morbidity

Recommendations: Development of a Dissemination and Implementation Plan for MMRC Findings and Recommendations

Create actionable recommendations to direct next steps and result in data to action.

- Utilize the MMRIA committee decision forms to identify case-specific recommendations by the MMRC
- Provide technical assistance to the MMRC on the Policy, Systems, and Environment (PSE) approach to result in actionable data driven recommendations that improve maternal health outcomes
- Analyze recommendations by levels of contributing factors and cause of death to allow for strategies and intervention design
- Explore opportunities for ongoing assessment of activities based on MMRC findings
    - Consider establishing an implementation committee to monitor and track data to action activities
    - Consider developing a strategic action plan with community stakeholders

Future meeting dates and agenda items

Upcoming Dates & Next Steps

- Nov. 14, 2019: Final Advisory Committee meeting, 8:30 am to 12 pm
- Nov. 22, 2019: Final draft of report due to Arizona Department of Health Services
- Dec. 31, 2019: Final report of the Maternal Fatalities and Morbidities Advisory Committee delivered to the Chairpersons of the Health and Human Services Committees of the House of Representatives and the Senate
- January 2020: Final report will be published online at www.azdhs.gov/maternalhealth

Call to the public

Meeting Adjourned

For all referenced materials:
www.azdhs.gov/maternalhealth

For additional inquiries: maternalhealth@azdhs.gov